Payment by Results system. Inaccurate coding of procedures may lead to significant losses for the hospital, however the degree of loss is unknown.
Aim: To ascertain the Royal United Hospital Bath's ENT clinic activity, and estimate potential unclaimed income from PCTs.
Method: A prospective review of ENT clinic activity and the coding of chargeable procedures over a one week period at a District General Hospital.
Results: 189 patients were seen in 7 clinics during which 84 chargeable procedures were performed. Only 10 (12%) of these procedures were recorded however, conferring potential lost earnings of £8,786 per week (£421,724 pa).
Conclusion: Failing to accurately record clinic procedures could lead to substantial departmental lost earnings. Although if each department were to accurately charge for their work the tariff system of PCTs would be unsustainable, this audit highlights the gap between PCT funding and the hospital procedural tariff use. Outpatient clinics must develop an efficient method of recording procedures to plug this financial gap.

0086: AUDIT OF TWO WEEK RULE REFERRALS FOR SUSPECTED HEAD AND NECK CANCER – A COMPARISON OVER TEN YEARS

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Aim: To audit the two week rule head and neck cancer referral pathway, with regards to its appropriate usage and the data obtained from it, and to compare this to an audit performed ten years prior.
Method: A list of two week rule referrals received by Wirral University Hospital between 1st January and 30th June 2012 was obtained. Proformas and case notes were reviewed to obtain data. This was compared with the previous audit from 2002.
Results: 357 referrals were received during 6 months, compared to 149 throughout 2002. 17% of referrals were incorrectly completed, improved from 37% previously. Overall pick up rate of cancers diagnosed as a result of two week referrals has fallen slightly to 5% from 9%.
Conclusion: The number of two week rule referrals made to ENT has increased over the past 10 years. Although improvements have been made regarding the quality of these, inappropriate and incomplete referrals are still received. Modifications to the proforma, and increasing education to primary care providers should be considered to improve both the quality of patient care, and the pressure of these referrals on ENT departments.

0141: SEPTAL BUTTON INSERTION: THE TWO-FORCEPS SCREW TECHNIQUE

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Nasal septal perforation has a variety of causes and patients can present with a range of symptoms. Those who require surgery are offered occlusion of the perforation using prosthesis or a surgical procedure. Patients are managed with a septal button if they are unsuitable to undergo surgery to close the perforation.
Insertion of a nasal septal button can be difficult and invariably requires general anaesthesia due to a moderate level of patient discomfort and operative complexity. A range of techniques and prostheses have been described in the literature. The senior author of this paper (SA) describes a technique which aims to simplify the insertion of a nasal septal button.
The method we describe for the insertion of a nasal septal button is easy to learn; the septal button is securely fitted in place, and this procedure can be performed with local anesthesia. In our experience, it does not have some of the problems encountered in similar procedures previously reported.

0160: SKIN EXCISIONS IN A DISTRICT GENERAL HOSPITAL

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Aim: To audit surgical clearance of skin cancer excisions performed by the ENT Department in a District General Hospital.
Method: Retrospective audit of primary skin excisions performed in Gloucester Hospital between January 1st and June 30th 2012. Patients identified using theatre logbooks and computerised pathology records. Age, sex, site of excision, histology of excised tissue and clearance margins were recorded.
Results: 94 excisions performed on 86 patients.
60% were benign pathology and 40% carcinoma/carcinoma in situ.
In malignant excisions, age range was 52 - 97 years, with an average of 78 and male to female ratio of 9:1.
Malignant pathologies included basal cell carcinoma (58%), squamous cell carcinoma (24%), baso-squamous carcinoma (8%), malignant melanoma (5%), squamous cell carcinoma in-situ (2%) and sebaceous carcinoma in-situ (3%).
The overall surgical clearance was 71% which increased to 81% when performed by an ENT surgeon with a specialist interest in skin.
Conclusion: A wide variety of skin lesions were encountered, providing training opportunities for Registrars. Whilst there is no clear 'Gold Standard' for acceptable clearance rates, particularly when dealing with the nose and ear region, our rate is comparable to others in the literature when performed by a skin specialist.

0211: IMPACT OF ELECTRONIC PATIENT RECORDS (EPR) ON ENT OUTPATIENT CLINICS

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Objectives: To assess the impact of EPR on patient clinics. Two audit standards were examined: the introduction of EPR should not reduce the time doctors spend with their patients; coding procedures on EPR should be performed correctly.
Methods: Time spent on EPR per clinic was recorded by each of the doctors in the department over a week. This was compared to a week before the introduction of EPR. In addition the number of flexible nasal endoscopes (FNE) recorded on the computer system was compared to the physical number of FNEs used.
Results: On average 1:38 min was spent on EPR per patient. Consultant clinic time per patient reduced from 15:57 to 13:19 min after the introduction of EPR. Middle grade and ear care clinics lengths increased (16:39 to 17:07 min and 12:36 to 13:33 min). The number of FNEs performed was 57, but only 11 were coded on EPR.
Conclusions: Patients spend less time with their doctors since the introduction of EPR. Overall, the time spent on EPR per clinic corresponded to an additional patient per clinic. The shift of responsibility to clinicians for coding procedures has financial implications: not coding FNEs correctly in the week examined cost £2226.40.

0281: THE NURSE-LED MASTOID CLINIC

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Aim: Mastoidectomy is a common otological procedure and a proportion of patients require long-term post-operative care for wax build-up or infection. We aimed to evaluate the utility of the nurse-led mastoid clinic (NLMC).
Methods: Retrospective notes review of 100 pseudo-randomly selected patients that were under the care of NLMC.
Results: These patients made a total of 4346 visits, a mean of 5.3 annual visits per patient. The average duration of follow-up was 8.2 years (range 1 to 16 years) but 38 patients had not been seen for the last 2 years. Majority (3172, 73%) of visits required wax removal. Topical ointment was used in 902 (20.8%) visits and 226 (5.2%) visits required a topical antibiotic prescription issued by a doctor. A total of 89 visits (2.0%) led to a referral to a medical clinic, the commonest reason being persistent infection (45 visits, 1.0%).
Conclusion: Many patients post-mastoid surgery require long-term care, which can be effectively provided in the NLMC; it gives patients rapid access in case of difficulties, whilst freeing up medical clinics for other patients. However, medical input remains important, both in terms of issuing topical antibiotic prescription and for review of problematic patients.

0359: MANAGEMENT OF NASAL FRACTURES IN A RURAL DISTRICT GENERAL HOSPITAL: A COMPLETED LOOP

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Aims: To determine if those patients referred to the ENT casualty clinic with suspected nasal fracture were all being managed correctly, with appropriate examination findings documented and appropriate examinations requested; and to set up an agreed protocol in nasal fracture management.
Method: A two cycle prospective audit was performed. Data was collected when patients were reviewed in the casualty clinic over a 3 month period.